# Core 400 LLC

**An Independent Review Organization**
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jan/05/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** continued physical therapy 3 x a week for 4 weeks

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ X ] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.** It is the opinion of the reviewer that the request for continued physical therapy 3 x a week for 4 weeks is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. The patient lifted a child on this date and injured the right shoulder. Initial evaluation dated 11/07/14 indicates that the patient completed 19 physical therapy visits; however, she reported minimal to no improvement with therapy and her passive and active range of motion decreased. The patient subsequently underwent right shoulder injection. Right shoulder active range of motion is flexion 130, abduction 130, external rotation 51 and internal rotation 70 degrees. Strength is rated as 3+/5 in abduction, 4/5 external rotation and flexion, and 4+/5 internal rotation.

Initial request for continued physical therapy 3 x week for 4 weeks was non-certified on 11/12/14 noting that since request exceeds ODG guidelines of 16 visits for adhesive capsulitis, approval cannot be recommended. The denial was upheld on appeal dated 12/02/14 noting that the patient has completed 1 physical therapy visits, per note dated 11/07/14 with minimal to no improvement. Current evidence based guidelines support up to 16 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. Additionally, ODG does not support the utilization of requested modality G0283, and there is no rationale provided to support aquatic therapy (97113). The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The patient sustained an injury to the right shoulder as a result of lifting a child on 06/02/14 and subsequently developed adhesive capsulitis. The submitted records indicate that the patient has completed 19 physical therapy visits. Evaluation performed in November reports that the patient reported minimal to no improvement with previous physical therapy, and in fact, both passive and active range of motion actually decreased. Therefore, efficacy of treatment is not established and additional physical therapy is not appropriate at this time. The Official Disability Guidelines would support up to 16 visits of physical therapy over 8 weeks for a diagnosis of adhesive capsulitis. Exceptional factors are not documented to support continuing to exceed this recommendation. The patient should be well-versed in a structured home exercise program at this time. As such, it is the opinion of the reviewer that the request for continued physical therapy 3 x a week for 4 weeks is not recommended as medically necessary and the prior denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

**[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

**[ ] INTERQUAL CRITERIA**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**[ ] MILLIMAN CARE GUIDELINES**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**[ ] TEXAS TACADA GUIDELINES**

**[ ] TMF SCREENING CRITERIA MANUAL**

**[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**